ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES

150 N. 18th Avenue, #450 Phoenix, Arizona 85007 **** 400 W. Congress Tucson, Arizona 85701

INITIAL APPLICATION FOR A HEALTH CARE INSTITUTION LICENSE

A.R.S. Title 36, Chapter 4 and A.A.C. Title 9

I. HEALTH CARE INSTITUTION INFORMATION

Name of health care institution		
Street address		
City	Zip code	Phone number
Tax I.D. number	Fax number	E-mail address
Mailing address		
City	State	Zip code
Requested health care institution class or subclass:(listed in R9-10-102)		
Requested licensed capacity:		

A. Is the proposed health care institution (except for a home health agency or a hospice service agency) located within 1/4 mile of agricultural land?
____Yes ____ No If yes:
1. Include on a separate sheet of paper the names and addresses of owners or lessees of any agricultural land within 1/4 mile of the proposed health care institution, and
2. Attach a copy of the written agreement between the health care institution owner and the owner or lessee of agricultural land prescribed in A.R.S. § 36-421(D).

B. Is the proposed health care institution located in a leased facility?
____Yes ____ No If yes, attach a copy of the lease showing rights and responsibilities of the parties.

C. If a proposed health care institution is not exempt from submitting architectural plans and specifications pursuant to A.R.S. § 36-422(E) attach one of the following:
1. A copy of DHS approval of the proposed health care institution's architectural plans and specifications, or
2. The architectural plans and specifications for the proposed health care institution required in A.A.C. R9-10-105(A)(5)(a).

D. Is the proposed health care institution ready for an inspection by Department representatives?
_____Yes ____ No If no, date the proposed health care institution will be ready

II. OWNER INFORMATION

Owner's name	
Address	
City	Zip code
Telephone number	Fax number

The owner is a: (check one)	_____Proprietary	_____Non-proprietary

The owner is a: (check one)	_____Sole proprietorship	_____Partnership
_____Limited liability company	_____Corporation	_____Governmental Agency

A. PLEASE LIST IN THE SPACE PROVIDED BELOW:
If the owner is a partnership, the name of each partner;

If the owner is a limited liability company, the name of the designated manager, or if no manager is designated, the names of any 2 members of the limited liability company;
If the owner is a corporation, the name and title of each corporate officer; or
If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Name	Title
Name	Title
Name	Title
Name	Title

B. If applicable, attach a copy of the articles of incorporation, the partnership documents, or the limited liability company documents.

C. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked or suspended?
____Yes ____ No

D. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked or suspended?
____Yes ____ No

E. If either of the above questions is answered yes, include on a separate sheet of paper for each yes answer:
1. The reason for the denial, suspension, or revocation;
2. The date of the denial, suspension, or revocation;
3. The name and address of the licensing agency that denied, suspended, or revoked the license.

Statutory agent (or individual designated to accept service of process and subpoenas)

Name	Title
Address	Telephone number

III. GOVERNING AUTHORITY

Name

IV. CHIEF ADMINISTRATIVE OFFICER

Name	Title
Education (list the highest educational degree obtained and any instruction related to the health care institution class or subclass for which licensure is requested)	
Experience (list work experience related to the health care institution class or subclass for which licensure is requested)	

V. SIGNATURES

According to A.R.S. § 36-422(B) an application must be signed, as follows:

(1) If an individual, by the owner of the institution;

(2) If a partnership or corporation, by two of the partners or corporate officers; or

(3) If a governmental unit, the head of the governmental department having jurisdiction.

A.A.C. R9-10-105(A) requires the application signatures to be notarized.

_____	_____
Signature Date	Signature Date
_____	_____
Title	Title
STATE OF_____)	STATE OF_____)
COUNTY OF _____)	COUNTY OF _____)
Subscribed and sworn to before me this	Subscribed and sworn to before me this
_____ day of _____,	_____ day of _____,
by	by
Notary Public	Notary Public
My Commission Expires	My Commission Expires

Attach:

1. Documentation from the local jurisdiction of compliance with all applicable local building codes and ordinances.
2. If accredited by a nationally recognized health care accreditation agency, a copy of the current accreditation.

For DHS use only: Correct application fee enclosed: _____ Yes _____ No Check #:

Instructions for completing HCI Application

PLEASE TYPE OR PRINT IN BLACK INK.
Please submit the application, with all required attachments and the required fee. This application will not be complete until all required attachments and fees have been submitted to the Department. If any corrections are made to the application using correction fluid or correction tape, the application will be returned. If you make a mistake filling out the application, put a line through the mistake and your initials.

I. HEALTH CARE INSTITUTION INFORMATION

Provide all required information.

"Tax ID number" means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Services. (If you are using an individual's Social Security Number, it will be treated as confidential information and redacted from the copy of the application in the facility's public file.)

According to Arizona Revised Statutes, Title 36, Chapter 4, or Arizona Administrative Code, Title 9, Chapter 10, a person may apply for a license as a **health care institution class or subclass**, which are listed below. **Select one of the following classifications and write it on the application**.

Abortion clinic	**Hospice**
Adult day health care facility	**Hospital**
Adult foster care	Nursing care institution
Assisted living center	**Outpatient surgical center**
Assisted living home	**Outpatient treatment center**
Home health agency	**Recovery care center**
Hospice inpatient facility	**Unclassified Health Care Institution**.

II. OWNER INFORMATION

"Owner" means a person who appoints, elects, or otherwise designates a health care institution's governing authority. "Proprietary" means an owner or owners. "Non-Proprietary means a leased business, franchise, or in certain instances, a Governmental Agency.

III. GOVERNING AUTHORITY

"Governing authority" means the individual, agency, group or corporation, appointed, elected or otherwise designated, in which the ultimate responsibility and authority for the conduct of the health care institution are vested.

IV. CHIEF ADMINISTRATIVE OFFICER

"Chief administrative officer" means the individual implementing a governing authority's direction in a health care institution. This is the on-site administrator, or the certified manager.

V. SIGNATURES – A.A.C. R9-10-105(A) REQUIRES THE APPLICATION SIGNATURES TO BE NOTARIZED

According to A.R.S, § 36-422(B) the application **must be signed**, as follows:

(1) If an individual, by the owner of the institution;
(2) If a partnership or corporation, by two of the partners or corporate officers; or
(3) If a governmental unit, the head of the governmental department having jurisdiction.